BRIDGE

Exploring Community Beliefs, Attitudes, & Behaviors Related to HIV/AIDS

Research Findings from Eight BRIDGE Districts in Malawi

September 2004

B R I D G E

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Dear Readers:

The HIV/AIDS epidemic looms over rural and urban populations in Malawi. National AIDS Commission (NAC) now estimates that there are approximately 70,000 new cases of AIDS each year in Malawi. Research shows that currently approximately 15% of adults aged 15-49 are HIV infected, translating into a 50% lifetime risk of contracting the virus. As a result, AIDS is now the leading cause of death in adults. By 2005, AIDS-related deaths are projected to rise to over 100,000 adult deaths annually. For 2003, a NAC HIV/AIDS in Malawi Report cited around 62,000 adult deaths annually.

In early 2004, The Center for Communication Programs (CCP) at the Johns Hopkins University, in collaboration with our partners in the Ministry of Health in Malawi, the National AIDS Commission, Save the Children, and Salephera Consulting, Ltd., conducted baseline research in eight districts in Malawi. This document is a brief summary based on findings from both the quantitative and qualitative research.

The three main objectives of the quantitative survey were to understand:

- Respondents' current engagement in HIV/AIDS-related behaviors;
- Risk perceptions, efficacy beliefs, normative perceptions, values, communication networks, and knowledge about HIV/AIDS; and
- The extent to which attitudinal and knowledge variables predict intentions to engage in safer-sex behaviors.

Quantitative research was conducted through survey interviews with 887 randomly selected people (405 male and 482 female) in the Balaka, Chikwawa, Kasungu, Mangochi, Mulanje, Mzimba, Ntcheu, and Salima districts. Comparisons were made between four groups: boys (15-24 years old), girls (15-24 years old), men (25+ years old), and women (25+ years old).

For the qualitative research, discussions were designed to reveal the attitudes, beliefs, concerns, perceptions and perceived risk related to HIV/AIDS. Nearly 100 youth, adults, and elders from two of the eight districts, Mangochi and Mzimba, were organized into focus groups by gender and age. Five focus groups took place in each district for a total of 10 focus group discussions (FGD). Girls and boys aged 15 to 25, women and men aged 26 to 49, and elders age 50 and above participated. The group dynamics as well as the non-judgmental atmosphere in which the FGDs took place allowed for collection of information on sensitive topics such as sexual practices and cultural traditions. Likewise, the participatory approach used during the FGDs helped uncover individual and societal factors that pertain to HIV/AIDS from participants' own points of view.

The BRIDGE project aims to use these research findings to help understand the motivations and mechanisms underlying the HIV/AIDS epidemic in Malawi. Ultimately, BRIDGE activities can change the way Malawians think and speak about HIV/AIDS, and most importantly help them adopt behaviors that prevent HIV transmission.

We also hope that these documents will assist other organizations working in Malawi. It is our belief that only a collective effort will slow the spread of HIV/AIDS and also quicken progress towards a more hopeful future.

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GLOSSARY OF TERMS

AIDS Toto Clubs Groups or clubs set up by the Ministry of Education and sponsored by NGOs for in-school youth. Activities include life skills, drama festivals on HIV and AIDS, peer-to-peer education, sports, and choir festivals.

Anti-retroviral drugs (ARVs) Pharmaceutical drugs prescribed to individuals who are HIV positive, to help slow progression of the virus in their body.

Attitude An individual's feelings about an object, person, or group, which influence his or her response towards it to be favorable or unfavorable. For example, John has a positive attitude about HIV testing, so he got tested.

Behavioral intentions A course of action that one plans to follow. For example, Sarah's behavioral intention is to use a condom at every sexual act.

Communal Having to do with a group or community as opposed to having to do only with an individual.

Demographic and Health Survey (DHS) MEASURE DHS assists developing countries worldwide in the collection and use of data to monitor and evaluate population, health, and nutrition programs. Demographic and Health Surveys provide national and sub-national data on family planning, maternal and child health, child survival, HIV/AIDS/sexually transmitted infections (STIs), infectious diseases, reproductive health and nutrition. A DHS was conducted in Malawi in 2000 and a new one is underway for 2005.

Efficacy Beliefs about the ability to take action to change one's life or circumstances.

Communal efficacy A group's beliefs about the ability to take action to change circumstances.

Entertainment-education Integrates educational messages into popular media entertainment formats – such as radio or TV serials, talk shows, comic books, and music – in order to show people how they can live happier and healthier lives, create favorable attitudes, and change their behavior.

Fatalism A belief that all events are predetermined and inevitable and individuals are powerless to change them.

HIV/AIDS Human Immuno-deficiency Virus/Acquired Immune Deficiency Syndrome. HIV is a virus that is transmitted by certain risk behaviors. HIV infection gradually weakens the immune system – the body's defense against disease. A person can carry the virus for a long time and not know it and look perfectly healthy. Eventually, the person develops AIDS, a condition where the immune system can no longer protect against other serious illnesses. It is these other illnesses which may eventually lead to death.

Contracting HIV When someone gets the HIV infection.

HIV transmission When someone who is HIV positive, infects someone else with the virus.

HIV test The only way to know for sure if a person is infected with HIV. It is a simple procedure and should only be carried out by a health care provider.

HIV status Whether a person is HIV positive or HIV negative, based on a confirmed HIV test. HIV positive means that someone has the HIV infection. HIV negative means that someone does not have the HIV infection.

Interpersonal communication (IPC) Being, relating to, or involving communication among people. IPC refers to how individuals relate, talk, and exchange information between one another.

Locus of control An idea that describes a person's sense of control over his or her own behavior, life, etc.

Internal forces When a person feels he or she is in control over behaviors and events happening in his or her life.

External forces When a person feels that other people, events, or circumstances (for example, poverty) have that control over the behaviors and events happening in his or her life.

Misconception A mistaken thought, idea, or notion; a misunderstanding. For example, a common misconception about HIV is that it can be transmitted from a mosquito to a human being.

Monogamy/Fidelity When someone has sexual relations with only one person throughout the duration of their relationship.

Negotiation The process of discussion or bargaining with the intent of reaching agreement. Also called shared-decision making.

Norm(s) A pattern or practice in the behavior of a social group that is accepted as typical of that group. These may also be referred to as community or social norms. For example, it is a social norm among Malawians that elders are the caretakers for AIDS orphans.

Peer-to-peer When people similar in age and experience share ideas and information.

PLWHA A short form for "Person or People Living With HIV/AIDS."

Positive deviant When someone differs from the norm, in particular, a person whose attitudes and behavior(s) differ from accepted social norms in ways which are beneficial or advantageous. For example, a positive deviant is someone who, despite pressures from a partner to have sex insists on waiting until marriage.

Qualitative research Research that gathers information through interviews and group discussions. It is designed to allow individuals to openly express their attitudes, beliefs, concerns, and perceptions. Focus group discussions were used to collect BRIDGE qualitative data.

Quantitative research Research that gathers information through responses to a survey or questionnaire. It is designed to allow individuals to relate their experiences and opinions by choosing from a series of possible responses, when asked a survey question.

Respondents and Participants Terms used to describe individuals who were involved in BRIDGE research. For the purpose of these fact sheets, generally "respondents" refers to the survey, and "participants" refers to the focus groups discussions.

Females For the purpose of this research, includes the girls (15-24 years old) and women (25+ years old).

Males For the purpose of this research, includes the boys (15-24 years old) and men (25+ years old).

Risk perception/Percieved risk When an individual can recognize, see, or understand the possibility of suffering harm, loss, or danger.

Risk factor Something that contributes to the possibility of suffering harm, loss, or danger. For example, having multiple partners is a risk factor for contracting HIV.

Role model A person who acts in a particular behavioral or social role for another person to imitate.

Severity The significance or seriousness of a threat.

Stigma, AIDS-related Prejudice and discrimination directed at people who have or who are perceived to have AIDS or HIV. This may be extended to individuals, groups, and communities with which they are associated.

Susceptibility The state of being sensitive to, or of lacking the ability to resist something.

Tolerance An attitude that allows freedom of choice and behavior; the willingness to recognize and respect the beliefs or practices of others even if they differ from one's own opinion.

Value judgment A decision about a person, object, or action that labels their worth as good or bad; a subjective evaluation.

Voluntary Counseling and Testing (VCT) An HIV testing approach that is voluntary, involves pre- and post- test counseling and should be confidential.

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GENDER

"But men especially are not faithful…they go to beer halls, bars, and get STDs and give it to their wives. Yes, there are some young women who do that, but the majority of them are men." (Mangochi elders)

The Female Perspective

Females are more vulnerable to HIV/AIDS than males. A woman's biology is part of the reason, but there are many social reasons as well:

- Lower levels of HIV/AIDS knowledge and lower risk perceptions add to female susceptibility to HIV. Adjusting for education, girls are the least knowledgeable about HIV/AIDS and its severity.
- Women feel themselves to be more emotionally and financially dependant on partners than men do:
  "But we're still young and are still searching for the right partner…we don't know how to find out properly the virus-free partner." (Mzimba girls)
- Females feel a lack of control, both internal and external, in many aspects of their lives, including in sexual decision-making like initiating condom use:

TABLE 1: Who Initiated Condom Use at Last Sexual Encounter

	Respondent	Partner	Jointly	Don't Know
Boys	79.2	8.3	8.3	4.2
Girls	60.0	25.0	10.0	5.0
Men	93.3	0.0	6.7	0.0
Women	38.5	23.1	15.4	23.1

According to Table I, women initiated condom use in their last sexual encounter less than boys, men or girls, indicating significant gender imbalance. Although women said they initiated condom use 38.5% of the time, men said that their partner never initiated condom use, which may point towards men's desire to be the primary decision maker. A similar pattern exists between boys and girls, too.

- Only 53.3% of female respondents said they know where they can get condoms, limiting their possibility of having protected sex.
- When women and girls were asked if they believe traditional healers have the power to cure AIDS, significantly more women than men think that it is possible.

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The Male Perspective

- Men also feel they lack control over certain situations. For instance, men feel powerless when it comes to preventing child prostitution. Some men complained that when women send their children to have sex for money, they feel unable to intervene.
- Boys appear to be better prepared to reduce individual risk factors for HIV, in comparison to girls, men and women.

Beliefs Related to HIV Status

Women and girls are less likely to think that a person, a friend, or a family member should tell others his or her HIV status:

- 23% of women in comparison to 13% of men believe that HIV status should be kept private;
- 20% of girls versus only 11% of boys think that status should be kept private; and
- 26% of girls versus only 10% of boys agree with the statement, "For safety, it is better to stay away from a person with AIDS."

In general, boys seem to differ substantially from the other three groups; they consistently expressed more positive attitudes towards PLWHA and status disclosure. These behaviors may work to reduce stigma.

Gender and Disciplinary Action

Physical punishment for girls and boys differed. To whip or beat a girl seems to be socially accepted when participants talked about a daughter who was having sex rather than when they talked about a son who was having sex.

Receiving Information

Male and female participants differ significantly in how they reacted to receiving information about HIV/AIDS. While female participants focus on communication with others (at home or in a club), men focus on action (individual and personal behavior change). This may be because men feel they have more control over their sexual behavior than women and therefore feel they can take action.

- Boys and men said that they go to the hospital for blood tests, abandoned past "immoral behavior," and started carrying condoms wherever they went.
- Girls and women, on the other hand, said that they share information with others (e.g. friends, mother, children), and plan to form a support group.

RECOMMENDATIONS

- Include both communication and action approaches in HIV/AIDS programming. The two approaches complement each other. Programming must take into account subtle (and sometimes obvious) gender differences.
- Improve women and girls' decision-making, negotiation, and efficacy skills to address inequalities in interactions between females and males, including safer sexual behaviors.
- Develop programs for males that show the advantages of gender-balanced relationships and decision-making. Include boys, men, and other members of the community in empowering girls and women to prevent HIV.
- Encourage economic development to help prevent the poverty that leads individuals to drastic measures for survival and that can spread HIV.
- Develop programs where men unify to help end child prostitution. They can approach it as fathers concerned about their daughters and other young women in their communities.
- Work with community leaders to support programs to improve knowledge, attitudes, and skills for HIV prevention. Help change contributing social factors that put women and especially girls at increased risk of contracting HIV, using entertainment-education and other innovative methods.

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COMMUNICATION

> ***"But telling my family about HIV/AIDS is important however, to tell girls and boys who are teenagers, I may feel shy, according to our culture."*** (Mangochi boys)

Respondents said they do not often have interpersonal discussions about sex and HIV prevention. This was particularly true within families and among men and boys. Focus group discussions also showed that it is hard for young people to talk to older people about HIV, sex, or condoms. However, focus group participants reported feeling comfortable talking to their friends about HIV/AIDS. They mentioned public settings as a good place for discussing HIV prevention and other reproductive health issues.

Trusted Sources of Health Information Communication

When asked whom participants would go to see to know more about HIV/AIDS, they mentioned as trusted sources:

- **Doctors** – "are knowledgeable and will tell the truth"
- **Hospital Workers** – "are knowledgeable and friendly"
- **Religious leaders** – "tell us what not to do"
- **AIDS Toto Clubs** – "instruct us in how AIDS is dangerous"
- **Health NGOs** – "give information on HIV/AIDS and family planning"
- **Community leaders** – are "trustworthy" sources

Types of Communication Media

Research shows that radio is a good tool for communicating HIV prevention information. According to the 2000 Malawi DHS, radio is the most popular form of mass media in Malawi, yet only 50 percent of rural Malawians have access to mass media of any kind. Our research supports the fact that radio is by far the most commonly used form of mass media, followed by newspaper or magazines. Only a small fraction of respondents watch television.

> *"Yes, we've heard a lot on the [radio]… They talk about how AIDS can spread and how one can contract HIV/AIDS. They also advise us to use condoms when having sex for protection from different STDs…including AIDS."* (Mzimba girls)

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The quantitative research showed that boys listen to the radio most frequently, about 5.2 days per week, and women the least, about 3.6 days per week. Among male and female radio listeners, 96% of males and 92% of females recalled having heard radio spots or messages with regard to HIV/AIDS in the last 30 days. They also reported having heard an HIV/AIDS radio spot an average of 6.8 times in the past 30 days. Despite radio's popularity, focus group participants said that batteries are expensive or difficult to find.

Parent - Youth Communication

Respondents said that it is an accepted social norm for parents to give advice to kids and reprimand them. Youth said that parents are authority figures whose central role is to punish and scold them when they are disobedient, especially about relationships with the opposite sex:

"…we parents shout; we shout at our children pleading with them that they should watch their lifestyles because the world is dangerous…we do speak strongly to our children telling them that…people are perishing." (Mangochi elders)

When asked what parents should do if/when they learned that their sons or daughters were active sexually, the most common responses were:

- "To give advice," which may include implicit orders, such as, "stop having sex;"
- "To give a warning," which may include the warning that they will beat their daughters if they continue having sex; and
- "To punish," which is usually physical (e.g. whipping, beating) and more common for daughters.

Girls and boys also stated that punishment can lead to banishment from the home:

"What do parents do when they hear that you are involved in sexual activities? They beat us…they throw boys out of the house…" (Mzimba girls)

RECOMMENDATIONS

- Develop entertainment-education communication programs that use radio and community-based media like street theatre, puppet shows, and song. Model effective communication between the different population groups, especially youth and trusted adults.
- Train parents, teachers, religious leaders, elders, and other adults in the community in interpersonal communication and counseling (IPC/C) skills in order to build trust and better communication with youth.
- Develop HIV prevention discussion points that people can bring into existing community settings such as congregational gatherings, "Open Days," festivals, and social clubs.
- Consider the use of wind-up and solar-powered radios to extend the reach of programming.
- Use peer-to-peer programming that builds on existing relationships. These should be well-funded and linked to other HIV prevention programs to be most effective.

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CONTROL & EFFICACY

> *"Ok, but among our youth self-protection is minimal, because they are easily sexually aroused…they fail to control themselves."* (Mzimba elderly)

Behavior is influenced by how much control a person feels over his or her life and circumstances. This sense of control in turn affects a person's confidence in his or her ability to take actions.

Control

Focus group participants said they often do not feel they have control over their lives. Some examples they gave are:

EXTERNAL FORCES – Feelings of lack of control are particularly strong for women, but exist for men as well. Females are sometimes encouraged to have transactional sex to support the family or to marry early, and often have little control over their partner's sexual practices (issue of multiple partners).

Poverty—Participants repeatedly said they feel a lack of control in their lives because they are poor. AIDS is only one of many problems identified as a result of poverty:

> *"Ok but the problem would be that one may not contract it, but because of poverty one may be enticed to sleep with the man who has offered her money. That's how one may contract the disease."* (Mzimba girl)

Abandonment—Many people feel abandoned. The elderly feel they have to fend for themselves in the face of loss and poverty; women feel alone with their children; and many children are orphaned by dying parents.

Fatalism—The majority of participants believe that having AIDS in one's destiny means that there is little a person can do to protect him or herself from the virus. Individuals do recognize the benefits of specific HIV preventive actions. However the immediate need for income (urgent enough to exchange sex for money) and the social and cultural importance of childbearing (unprotected sex) mean that many have lost hope of escaping HIV infection:

> *"AIDS is really a punishment, because when God made rules he expected his children to follow. If a person disobeys, even at school, they are punished. Therefore, God has sent this disease so that we fear and stop our disobedience."* (Mzimba elderly)

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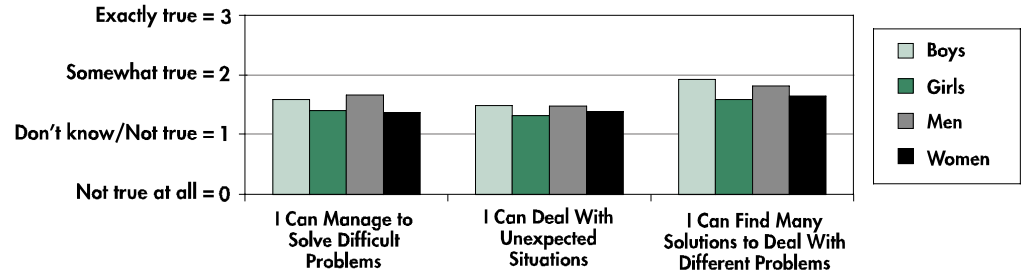
Fatalism in the quantitative research was measured in terms of respondents' perceived control and ability to deal with problems in their lives. When asked questions about problem solving, respondents could answer with one of the following: 0=Not true at all, 1= Don't know/Not true; 2= Somewhat true; 3=Exactly true. Their answers are represented by respondent group in Figure 1 below.

FIGURE 1: Perceived Control & Ability to Solve Problems



The four respondents differed from each other on perceived ability to "Manage to solve difficult problems" and "Find many solutions". Overall, about 33% of all respondents held fatalistic attitudes with regard to overcoming everyday problems. This sense of being overwhelmed seems particularly strong among females, compared to males.

INTERNAL FORCES — Men and women reported having sexual desires that are difficult to control. They express having uncontrollable sexual desires that drive them to have sex, usually without a condom:

"Ok, sleeping with prostitutes is indeed bad, but the fact that sometimes I stay very far from our village, thus our wives, then it becomes difficult to resist them, finally we just do such bad things." (Mzimba male)

Ability to solve problems— Men and women expressed different opinions on their ability to solve difficult problems and find solutions. In general, males feel they are more able to solve every day problems than females. This may be because men and boys are used to making decisions in society more often than women and girls.

Efficacy

Efficacy is a person's beliefs about the ability to take action to change his or her life or circumstances. The majority of research participants felt a strong sense of hopelessness and an inability to change their future.

Efficacy differed across the four respondent groups (men, women, girls, boys):

- Overall both boys and girls feel more able to practice HIV prevention behaviors than the older generation;
- Women feel particularly powerless; and
- Males feel more in control over their own decisions than females.

In the quantitative findings, respondents feel greater ability to remain abstinent and be faithful and lower ability to use condoms. In contrast, the focus group participants expressed low efficacy for abstinence or faithfulness:

"It is a habit not to be faithful." (Mangochi girls)

Further analysis of the data supported the assumption that it is possible to influence an individual's sense of efficacy to adopt specific HIV prevention behaviors, even when overall feelings of control are low.

Communal Efficacy Related to HIV/AIDS

Respondents felt strongly that a community can join together to fight HIV/AIDS, care for community members, and change community norms. This finding shows that people have a sense of communal efficacy—in other words, confidence in a community's ability to change its circumstances. Focus group discussions revealed a similar pattern:

> *"Since [she] comes from our village, she could be assisted in many ways. She can be trained or informed if she comes in close contact with the health personnel at the clinic. Her family members who are knowledgeable about HIV/AIDS could also talk to her. If she is religious, the church can also assist through church-leaders that are knowledgeable about HIV/AIDS. Village volunteers who teach on HIV/AIDS could also assist."* (Mangochi elderly)

When participants discussed why they worry about HIV/AIDS, the reasons they gave were more related to the collective well-being of the community than to personal, individual health:

> "*They are concerned because those who are dying are the ones who can help develop this village…"* (Mangochi girls)

Participants – female and male youth, adults and elderly alike – were worried about HIV/AIDS, because of its social consequences which include:

- Many people die;
- Productive people die;
- The elderly are left alone to fend for themselves; and
- Children become orphans.

RECOMMENDATIONS

- Improve individuals' efficacy about HIV/AIDS-related behaviors, including decision-making around condom use and limiting their number of sexual partners.
- Support comprehensive, integrated approaches to HIV/AIDS prevention that involve non-traditional sectors such as agriculture, education, or youth and sports. Include coordination mechanisms and an all encompassing workplan.
- Build self and community confidence and HIV prevention skills using activities that offer people concrete opportunities to develop their sense of internal and external control and efficacy.
- Work towards the collective empowerment of communities to look after and support their youth, particularly young girls, building on a theme of hope.
- Make use of role models and positive deviants in programming.

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KNOWLEDGE & PREVENTION

> *"HIV/AIDS has spread because we have forgotten and do not follow instructions that our forefathers used to say, not to have sex before marriage, if married, not to have other women besides your wife. We have become so free these days, that is why HIV is spreading fast."* (Mzimba elderly)

Most survey respondents have at least heard of AIDS:

- More than 90% of individuals said that they are aware of the disease;
- Girls and women are less aware than boys and men of the disease; and
- More than 80% of the respondents know about mother-to-child HIV transmission.

FIGURE 1: Overall Knowledge About HIV/AIDS

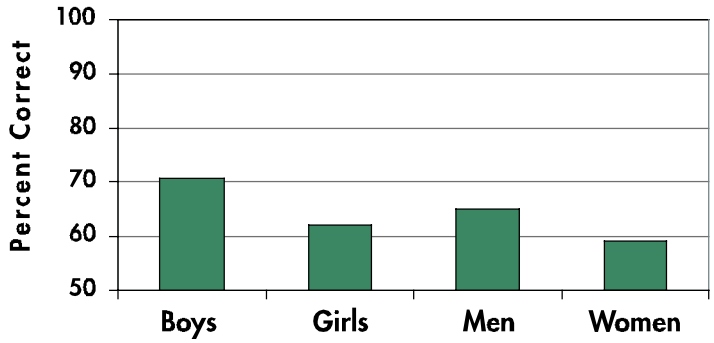

Figure 1 is based on 15 questions that respondents were asked about HIV transmission, prevention, and risk factors. As the figure shows, boys are most knowledgeable about the disease; adult women are the least knowledgeable. Knowledge about HIV/AIDS is also highest among those with secondary education or higher.

Prevention

Respondents pointed to the uncertainty of knowing the sexual practices or HIV status of their spouse or partner:

"You may want to protect yourself against HIV/AIDS, ok, but your partner does not have the very same attitude." (Mangochi boys)

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Responses to the survey question, "Is AIDS preventable?" indicate that most individuals do recognize that AIDS is in some way preventable. 97% of boys, 94% of men, 92% of girls, and 89% of women surveyed think AIDS can be prevented. Despite this uniformly high recognition, the possibility of a partner having multiple sexual partners can increase one's own risk of HIV infection.

Condom Use Behavior and Knowledge

Among sexually active survey respondents, 30% of boys and 20% of girls reported condom use during their last sexual encounter compared to only 8% of men and 1% of women. Although this may reflect more stable relationships, it also increases the risk of HIV transmission among older adults.

Both quantitative and qualitative research participants had moderate to low knowledge of the benefits of condom use (to avoid pregnancy and prevent diseases):

- When respondents were asked why they mainly used a condom during their last sex, only 43% of boys, 30% of girls, 25% of men and 50% of women responded, "for the purpose of disease prevention." This may suggest lack of knowledge and/or low perceived risk of sexually transmitted infections among respondent groups.
- Boys scored the highest and women scored the lowest when asked about their confidence in being able to use a condom every time they have sex. Similarly, women feel the least able to insist that their partner use a condom, while boys feel the most comfortable doing so.
- Focus group participants mentioned more reasons not to use condoms than reasons to use them. As a result, the consistent and correct use of condoms among respondents is very low. Reasons for not using condoms:
  - They are difficult to use, especially when things are "already heated up";
  - They are not 100% reliable, may be expired or damaged;
  - They are unnecessary if there is trust in the relationship;
  - They cause sores on the penis and may widen the vagina; and
  - They prevent people from having children.

In general, boys scored the highest, and women scored the lowest when asked about their confidence in being able to use a condom every time they have sex. Similarly, women feel the least able to insist that their partner use a condom, while boys feel the most comfortable doing so.

Misconceptions about HIV and AIDS

Despite moderately high knowledge and awareness about HIV and AIDS, respondents have many misconceptions:

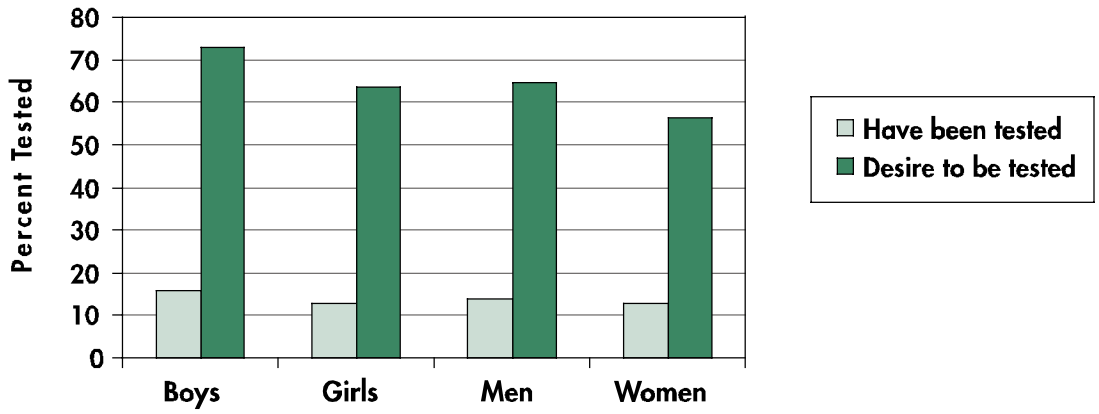
- 60% believe that one can acquire HIV from mosquito bites;
- 71% believe that having sex with only one person protects them from HIV (without considering that their partner may have had sex with others); and
- Focus group participants report that condoms may carry diseases including HIV.

There was confusion among participants about the difference between HIV and AIDS. With no cure for AIDS, it is not surprising that many participants thought that having HIV is the same as having AIDS. After all, in most discussions the two are used together: "HIV/AIDS." Respondents perceive both as a death sentence and there has been little effort to educate people about the difference.

HIV Testing

Most research participants have not gone for HIV testing despite saying they would like to be. Young people in particular say they want to know their HIV status; many reported that they cannot afford testing or do not know of a testing facility.

FIGURE 2: Already Tested for HIV and Desires to be Tested



Despite their desire for HIV testing, individuals feel a deep sense of hopelessness and helplessness about learning their HIV status:

- They think that a positive test will lead to depression and ultimately to suicide;
- They believe that they will die faster if they know that they are HIV positive because the anxiety will kill them; and
- They question the usefulness of being tested because they don't know whether or not their partner is faithful to them, something they cannot always control.

RECOMMENDATIONS

- Improve correct HIV/AIDS related knowledge, an important area of continued emphasis, given that there are still many misconceptions about the disease.
- Programs should distinguish between HIV and AIDS. Stress that people who are HIV positive can maintain healthy lives and AIDS can be managed through proper use of anti-retroviral drugs and treatment for opportunistic infections.
- Include the benefits of individual and couple testing and knowing one's HIV status in campaign messages.

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RISK PERCEPTION

> *"Yes but it is impossible that I shouldn't get the various diseases, my husband is promiscuous."* (Mangochi Women)

Risk perception is defined as an individual's ability to judge whether he or she is susceptible to a condition and determine how severe or serious the outcome will be.

Most respondents strongly agreed that AIDS is a severe disease. However, when asked whether they could become HIV positive, respondents felt only moderately susceptible to infection. Boys feel the most susceptible over time: when asked to project their risk 10 years from now, 100% responded they could become HIV positive. 95% of women thought they could be HIV positive within 10 years, and men and girls were at 87% and 86% respectively.

Assessing Risk Perception

Based on responses to questions about risk perception and efficacy, survey respondents were arranged into four categories:

1) **Indifference** - This group has low risk perception and low efficacy. In general, members of this group feel most life events are out of their control. They do not want to know their HIV status. They have lower problem-solving abilities. This group tends to be older and had sexual debut later in life.
2) **Proactive** - This group has low risk perception and high efficacy. The members of this group have a higher level of education, greater knowledge, greater problem-solving abilities, and had their sexual debut earlier in life.
3) **Avoidance** - This group has high risk perception and low efficacy. This group is overall less educated and less knowledgeable about HIV than the other groups.
4) **Responsive** - This group has high risk perception and high efficacy. Respondents in this group generally feel in control of their lives. They desire to know their HIV status, and they are usually younger.

Women are over represented in the groups with lower efficacy (Indifference and Avoidance). There are a greater percentage of males, compared to females, in the higher efficacy groups (Proactive and Responsive).

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FIGURE 1: Behavioral Intentions of the Four Risk Perception Groups

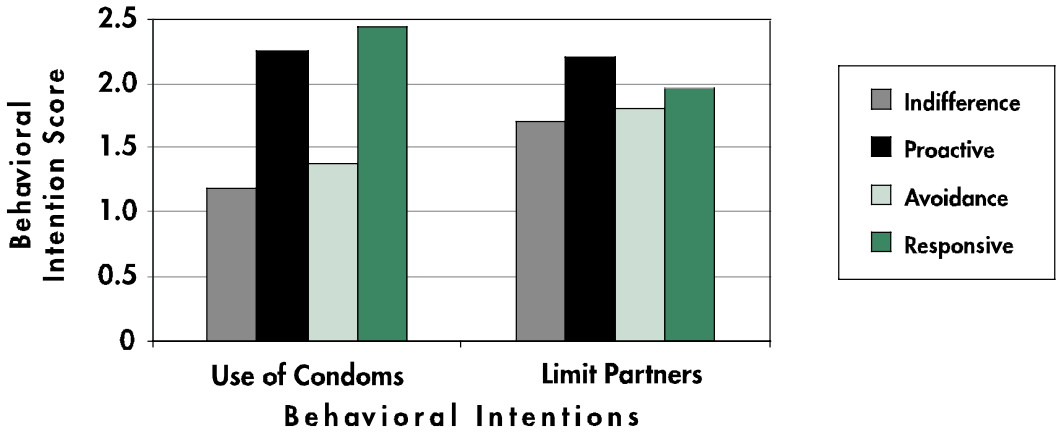

Figure 1 shows how respondents in the four groups scored in terms of their intentions to use condoms and to limit their number of partners. Measurements were on a scale of 0-4, higher values show a positive behavioral intention.

As predicted, the Indifference and Avoidance groups have the lowest HIV-protective behavioral intentions. On the other hand, the intention to practice safer sex behaviors is the strongest among the Proactive and Responsive groups, the two groups with higher feelings of efficacy.

These results show that an individual's risk perception and efficacy beliefs moderate the effects of background variables (e.g. education, age, desire to know HIV status, etc.) on behavioral intentions. In other words, people who have confidence in their ability to practice safer sex behaviors and recognize that they may be at risk, are more likely than their peers to adopt these behaviors.

Communal Risk Perception

Our research showed that individuals fear the impact of AIDS on society and the economy more than its effects on personal health. Since the majority of AIDS deaths are among people in the prime of life, community members worry about the elderly having to fend for themselves, the loss of productivity, and orphans. Participants feel that the greatest potential consequence of AIDS is the disappearance of community:

> *"We worry because you have lost your child, the sole support of the family and the children are left with the grandparents who were also relying on the ones who have died. It becomes a hopeless situation."* (Mzimba women)

RECOMMENDATIONS

- Behavior change interventions must focus on supporting people to regain control over the behaviors and decisions necessary to protect them from HIV infection.
- Programs must also underscore a sense of personal risk for contracting HIV/AIDS, coupled with small do-able actions for HIV prevention.
- Show positive, interpersonal communication, decision-making, and safer sexual practices in entertainment-education programs that reach rural and urban communities.
- Programs must include components that recognize the importance of the community's survival and its role in keeping individuals healthy.

BRIDGE

SOCIAL & CULTURAL FACTORS

> *"In my opinion our grandparents do not do well because sometimes they…have no money to buy salt, they send the girls to go and have sex with boys hence they have it so often and early."*
>
> (Mangochi boys)

During focus group discussions participants were encouraged to freely express their issues and concerns related to HIV/AIDS. Respondents suggested that social and/or cultural practices may contribute to HIV transmission rates.

Initiation Ceremonies

Boys and girls initiate sexual activity at an early age. Sex does not seem to be a taboo subject among respondents. Within their own generation, people talk about sex openly. Those who spoke out about cultural practices, like initiation ceremonies, accepted such practices without any value judgment:

"Because when he is leaving the initiation place, he is told that once he has left … he must throw away the ashes (i.e. have sex)." (Mangochi women)

"Females who have also just come from Msondo (girls' initiation ceremony), they too throw away dust by sleeping with boys who have just come from Jando." (Mangochi girls)

Traditional Healers

Most participants are aware of the limitations of traditional healers in treating AIDS. In fact, most are of the opinion that some traditional practices might put them at risk of contracting the disease:

"This disease does not only affect those who are promiscuous; some get infected at the traditional healers where they have mphini on the body."* (Mzimba elderly)

****Mphini*** are small cuts made on a person's body for tattooing or administering traditional medicine.

From the quantitative research, 18% female and 13% male respondents agreed with the statement that, "Some traditional healers have the power to give special protection so that one will not get HIV no matter how many sexual partners one has." Similar percentages of agreement prevailed when asked if traditional healers have the power to cure AIDS.

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Shared Rooms

In most communities, young people share rooms with adults and elders and may watch them have sex. According to participants, this leads young people to imitate with their peers what they see at home:

> *"A boy less than 15 years [old] sleeps in the same house with his brother, who most often brings a girl to the house. This boy one night is determined not to sleep until he … [sees] what his brother does with this girl; when he saw it he wanted to try it as well."* (Mangochi boy)

Normative Perceptions

All four survey respondent groups have perceptions about sex that influence their risk of HIV infection or transmission:

- About 10% of male and 11% female survey respondents feel that abstinence is unhealthy.
- Girls and women believe more strongly (than boys and men) that most friends and people in their villages have more than one sexual partner.
- Boys were the most likely and girls the least likely to believe that a woman doesn't have the right to ask her partner to use a condom.
- Girls reported being more influenced by their peers and what other people in their village are doing, than the other three respondent groups.
- Men reported being uninfluenced by their peers or villagers.

Social and Cultural Contradictions

In both the survey and the focus groups, respondents said people behave in ways that go against social and/or cultural expectations or roles. Some examples include:

- Children are told not have sex before marriage. However parents often send children to initiation ceremonies that may include intercourse.
- Female prostitution is condemned, but many respondents spoke of young girls exchanging sex for money or goods from "friends," "lovers," or "clients."
- Society values monogamy in marriages; but because of poverty, women may have sex for money or gifts to supplement the family earnings. In their search for income, men often travel for work; infidelity is common when they are away from their wives or still at home.

RECOMMENDATIONS

- Work with traditional initiator groups and their leaders to identify the harmful aspects of initiation ceremonies. Find ways to maintain the cultural practices without exposing young people to HIV and other potential health risks.
- Work with traditional healers to modify treatment practices that contribute to the risk of HIV or other infections.
- Work with religious leaders, who can teach people about HIV through sermons, congregational gatherings, group prayer services, and catechism.
- Develop income-generation possibilities for all family members as a programmatic priority.

BRIDGE

STIGMA

> *"But when you find out that you are positive, you feel like you are already dead because of the insults that you receive."*
>
> (Mangochi boys)

Negative attitudes towards people living with HIV/AIDS (PLWHA) are prevalent. About a third of survey respondents believe in isolating PLWHA. However, despite the stigma associated with HIV, a majority of survey respondents believe that PLWHA should be treated as well as other members of the community. Respondents also reported their families would take care of AIDS patients.

TABLE 1: Treatment of People Living with HIV/AIDS

TREATMENT CATEGORIES	How they are treated now	How they should be treated
Like everyone else	40.8%	50.7%
With more sympathy	28.3%	42.3%
Isolated from family	9.8%	3.2%
Mistreated by family	9.8%	0.0%
Don't know	11.3%	3.8%

This research shows that:

- Most people said they don't have negative attitudes towards PLWHA. However, the majority believe that other people would.
- All four respondent groups believe that PLWHA should be treated better than how they are treated now.
- Boys have significantly higher levels of tolerance and acceptance for PLWHA than the other three survey groups.

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Concern for PLWHA

Despite a fear of contracting HIV and somewhat negative attitudes towards PLWHA, 95.8% of respondents said that they would be willing to personally care for a family member who is sick with AIDS.

- Over 80% of respondents reported that PLWHA should get the best medical care available.
- Several participants showed concern towards PLWHA that reveal a sense of communal cohesion:

  "If someone gets sick from HIV/AIDS in our village we become unhappy; we get psychologically disturbed, troubled because we see how the disease is affecting the person." (Mzimba women)

Stigma and HIV Testing

Some reasons people give for not getting tested are related to the stigma of being HIV positive:

"… but if others [people] know that you have the disease, they laugh at you, they start to stigmatize you. They may want you to eat separately, use a separate bath and may not want to chat or spend time with you for fear of getting infected. These may create fear or anxiety and [people who have the disease] may commit suicide." (Mzimba elders)

- It is difficult for people to decide whether they want to know their status for fear of the reaction they will receive from their community.
- More girls and women than boys and men feel that if a person has AIDS, their positive status should be kept private.

RECOMMENDATIONS

- Gear campaigns towards HIV stigma reduction to help reduce discrimination towards and suffering of PLWHA.
- Reduce stigma and promote openness around HIV testing. More people would get tested if they were not afraid of the stigma of a positive test result.
- Encourage PLWHA to participate not only in HIV programming events, but also in daily community activities.
- Advocate for policies, programs, and funding for accessible Voluntary Counseling and Testing (VCT) facilities and mobile units nationwide.